pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

OPIATE DEPENDENCE TREATMENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines and Quantity Limits/Daily Dose Limits are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request PA# _____	total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
Facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested:	☐buprenorphine SL tablet ☐Suboxone SL film	**Non-preferred medication requested:**	☐Bunavail buccal film ☐buprenorphine/naloxone SL tablet	☐Zubsolv SL tablet ☐_____
Strength:	Directions:	Qty:	Requested duration:	Prescriber's DATA 2000 waiver DEA number:

****** For Vivitrol requests, use Vivitrol Fax Form. * * * * * * For Probuphine requests, use Probuphine Fax Form. ******

Diagnosis (*submit documentation*):	Dx code (*required*):
1. Is the prescriber enrolled in the Pennsylvania Medical Assistance (MA) Program?	☐Yes ☐No
1. Is the MA Recipient, or any other person, being billed any amount (above the standard MA copay) for the Recipient's office visits?	☐Yes ☐No ***Prescriber signature (required):*** _____
2. Is the Recipient taking a benzodiazepine? *Submit Recipient's current medication list.*	☐Yes – list: _____ ☐No
3. *Submit documentation* of results of a recent UDS for licit & illicit drugs of abuse (including buprenorphine, norbuprenorphine, oxycodone, fentanyl, carisoprodol, and tramadol).	
4. Did the prescriber or prescriber's delegate search the PDMP to review the Recipient's controlled substance prescription history before issuing this prescription for the requested medication?	☐Yes ☐No *Submit documentation.*
5. *If the Recipient has been **taking an oral buprenorphine agent for > 12 months***, has a clinical assessment of treatment effectiveness and appropriate dosage been performed?	☐Yes – *Submit documentation.* ☐No or N/A
6. ***For non-preferred requests***: Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred oral Opiate Dependence Treatments listed above?	☐Yes ☐No *Submit documentation for all agents tried.*

INITIAL requests

Check all of the following that apply to the Recipient and ***submit documentation for each item checked***.

- ☐has documentation of a history that supports the diagnosis of Opioid Use Disorder based on Diagnostic & Statistical Manual (DSM) criteria AND one of the following:
  - ☐initial UDS that supports an opioid use disorder diagnosis (including testing for substances of abuse)
  - ☐active withdrawal documented by a Clinical Opiate Withdrawal Scale (COWS) score of ≥ 9 at treatment initiation
  - ☐history of opioid use disorder with cravings
- ☐has documentation of a signed consent form authorizing release of Recipient's medical information as it relates to this request
- ☐has an initial or scheduled evaluation by a licensed D&A provider or Single County Authority (SCA) to determine level of care
- ☐is participating in, or has been referred to, a licensed D&A program as recommended in the initial evaluation by D&A provider or the SCA
- ☐has documentation of a mental health screening
- ☐if diagnosed with a co-occurring mental health disorder, is receiving, or has been referred for, treatment

RENEWAL requests

Check all of the following that apply to the Recipient and ***submit documentation for each item checked***.

- ☐has a documented history in the medical record of abstinence from alcohol
- ☐is participating in, or has successfully completed, a licensed D&A program at the recommended level of care
- ☐if successfully completed the licensed program, is participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program
- ☐if diagnosed with a co-occurring mental health disorder, is receiving, or has been referred for, treatment

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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